WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-X)

## CERTIFICATE OF DEATH

06100

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 7 days

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Route #2, Baltimore Pike
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Anderson, Leo Walter (LEO WILBUR ANDERSON)

**3. (b) Social Security Number:** 217-10-4964

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Ada Ruth Elbin

6(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): June 8, 1903

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 0 | 8 | ____ hrs. ____ min. |

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Engineer - Insulation

11. Industry or business: Celanese Mill - Celanese

FATHER 12. Name: George Isaac Anderson

FATHER 13. Birthplace: Winchester, Va.

MOTHER 14. Maiden name: Clara Rice

MOTHER 15. Birthplace: Near Cumberland - Valley Rd.

16. Informant: Mrs Ada Anderson

Address: R. F. D. #2 - Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 18, 1940 (month) (day) (year)

Cemetery or crematory: Pleasant Grove

Location: Baltimore Pike - Cumberland Md.

18. Funeral director: Jacob Hafer

Address: Cumberland, Md.

19. June 17 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: June 16, 1940 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9, 1940 to June 16, 1940, and that I last saw him alive on June 15, 1940.

| Immediate cause of death | DURATION |
|---|---|
| Bichloride Poisoning | 1 day |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 6-9-40

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. C. Bowers M. D. or other

Address: Cumberland Md. Date signed 6-16-40

LETTER in permanent file July 20 1940 under Dr. Bowen
making surname explicit. L.

RECEIVED
JUL 8 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

25101

**1. PLACE OF DEATH:**

County: Allegany

City or town: Ft Hart

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Ft Hart Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Rose Rosanora Arnone

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | married |

6 (b) Name of husband or wife: Joseph Arnone

6 (c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): March 19 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 | 3 | 5 | hrs. min. |

9. Birthplace: Italy (Town, county, and State)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Joseph Rosanora

13. Birthplace: Italy

MOTHER — 14. Maiden name: Antoinette Noce

15. Birthplace: Italy

16. Informant: Modestine Arnone

Address: Eckhart, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27-1940 (month) (day) (year)

Cemetery or crematory: St Michaels

Location: Frostburg, Md.

18. Funeral director: J. J. Dunn

Address: Frostburg, Md.

19. 6-26 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1940, at 11:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sudden 19 Death 19, and that I last saw h alive on 19

| Immediate cause of death | DURATION |
|---|---|
| Dropped Dead in her yard - evidently due | Sudden |
| Due to to Cerebral Hemorrhage | |
| Due to Hypertension | 1 year |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations: no

Of autopsy: no

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm McLane Jr Md M. D. or other

Address: Frostburg Md Date signed 6-25-40

RECEIVED
JUL 3 1940
BUREAU OF

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (193)

Reg. Dist. No. 4

## CERTIFICATE OF DEATH

06102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

**1. PLACE OF DEATH:**

(a) County: Allegany

(b) City or town: Cumberland
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Near Harding Ave. Cumberland

(d) Length of stay in hospital or inst. (yrs., mos., or days):

(e) Length of stay in this community (yrs., mos., or days):

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State: Maryland (b) County: Allegany

(c) City or town: Cumberland
(If outside city or town limits, write RURAL and give town)

(d) Street No.: 445 Penna. Ave.
(If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME**: Wilbur Earl Aronhalt

3 (b) If veteran, name war:

3 (c) Social Security No.: 220-10-5213

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife:

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 2, 1917

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 23 | 5 | 12 | ____hr. ____min. |

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Lineman

11. Industry or business: Potomac Edison Power Co.

FATHER
12. Name: Wilbur S. Aronhalt
13. Birthplace: West Va.

MOTHER
14. Maiden Name: Mamie Norris
15. Birthplace: West Va.

16 (a) Informant: Wilbur S. Aronhalt
(b) Address: 445 Penna. Ave. Cumberland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17, 1940 (month) (day) (year)
(c) Cemetery or crematory: HillCrest Cem.
Location: Baltimore Pike

18 (a) Funeral director: J. C. Wolford
(b) Address: Cumberland, Md.

19 (a) June 17, 1940 (Date rec'd by registrar) (b) J. P. Franklin, M. D. Registrar

**MEDICAL CERTIFICATION**

20. Date of death June 14, 1940, at ____M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1940, to June 14 1940, and that I last saw him alive on June 14 1940.

| Immediate cause of death | Duration |
|---|---|
| Electrical Shock | |
| Due to Contact c high tension wire 2300 V. | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: June 14 1940
(c) Where did injury occur? Cumberland, Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? Yes
(e) Means of injury: At work

23. Signature: W. Boyce Hodges, M.D.
M. D. or other
Address: Cumberland, Md. Date signed 6/15/40

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

## CERTIFICATE OF DEATH

06103

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 248 Williams St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 year

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 248 Williams St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Rev. Walter Franklin Atkinson

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Lovilla Fry

6(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1883

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 10 | 17 | hrs. min. |

9. Birthplace Clayton N.J. (Town, county, and state)

10. Usual occupation Minister.

11. Industry or business Methodist Episcopal Church

FATHER 12. Name George Atkinson

13. Birthplace New Jersey.

MOTHER 14. Maiden name Mary Nelson

15. Birthplace Unknown

16. Informant Mrs. W. F. Atkinson

Address 248 Williams St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22, 1940 (month) (day) (year)

Cemetery or crematory Harleigh

Location Camden N. J.

18. Funeral director Jacob Hafer

Address Cumberland Md.

19. June 20 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

Dr Jacobson

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1940, at 12 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1940, to June 19 1940, and that I last saw him alive on June 19 1940

| Immediate cause of death | DURATION |
|---|---|
| Acute Edema of Lungs | 8 hours. |
| Due to Cardiac Decompensation | ? |
| Due to Rheumatic Cardiovascular Disease | ? ? |
| Other conditions | ? ? |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Jacobson Md M. D. or other

Address 119 Bedford St Date signed 6/20/40

RECEIVED
JUN 21 1940
BUREAU V. R.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (632)

## CERTIFICATE OF DEATH

06104

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS.A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: 526 Broadway Circle
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 70 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 526 Broadway Circle City
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Mary Elizabeth Bishop

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 0 | 21 | hrs. min. |

9. Birthplace Eckhart Allegany Md
(Town, county, and state)
10. Usual occupation Clerk (Retired)
11. Industry or business Department Store
FATHER 12. Name John Bishop
13. Birthplace Carnwell England
MOTHER 14. Maiden name Mary Pearce
15. Birthplace Doe Gully W Va
16. Informant Miss Ada Bishop
Address 526 Broadway Circle City
17. Burial Date thereof 6/6/40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland Md
18. Funeral director William H Kight
Address Cumberland Md
19. June 6, 1940 J. L. Mauklin, M. D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 4 1940, at 11½ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1940, to June 4 1940, and that I last saw h alive on 19

| | DURATION |
|---|---|
| Immediate cause of death: Probable Acute Cardiac dilatation | June 4 - 40 |
| Due to: Chronic Myocarditis | ? |
| Due to: | ? |
| Other conditions: Toxic thyroid | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Royce Hodges, M. D.
Address Cumberland, Md M. D. or other
Date signed 6/5/40

RECEIVED
JUL 8 1940
BUREAU V. S.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

(61) 10 06105 4

**1. PLACE OF DEATH**

County Allegheny Registration Dist. No. 4

Village or City New Town Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U.S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

**2. FULL NAME** PETER-M-BOWMAN

(a) Residence: No. Mt Savage RD #4 St., Ward.

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Alice Bird Bowman

6. DATE OF BIRTH (month, day, and year)

7. AGE: Years 60 | Months 5 | Days 22 | If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farming

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Laborer

10. Date deceased last worked at this occupation (month and year) May 2 - 1940

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Summit Twp. (State or country) Somerset Co Penna

FATHER

13. NAME Urias M Bowman

14. BIRTHPLACE (city or town) Summit Twp (State or country) Somerset Co Pa

MOTHER

15. MAIDEN NAME Julia Bittner

16. BIRTHPLACE (city or town) Somerset Co Pa (State or country)

17. INFORMANT ✓ John H. Yeu (Address)

18. BURIAL, CREMATION, OR REMOVAL

Place Meyersdale Pa Date June 9, 1940

19. UNDERTAKER Stanley M Thomas (Address) Salisbury Pa

20. FILED 6/8, 1940 H. J. Boettler M.D. Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** June (Month) 6 (Day) 1940 (Year) 8:00 P.M.

22. I HEREBY CERTIFY, That I attended deceased from Jan 1-1939, 19__, to March 1, 1940

I last saw him alive on March 1st, 1940; death is said to have occurred on the date stated above, at ___ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Uncontrolled Diabetes mellitus | 3 |
| Cerebral hemorrhage | 5-4-40 |

Other Contributory Causes of Importance:

Name of operation None Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19__

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. Alfred Van Ormer M. D.

(Address) Cumberland, Md

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

## CERTIFICATE OF DEATH

06106

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days): 5 Da.
Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 107½ Blaul Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** William J. Britten

**3. (b) Social Security Number:** 220-07-6420

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Louise Godsey Britten
6(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Mar. 23, 1880

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 2 | 29 | hrs. min. |

9. Birthplace: Cumberland Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: W.P.A.

FATHER
12. Name: Joe Britten
13. Birthplace: Maryland

MOTHER
14. Maiden name: Bridget McGann
15. Birthplace: Maryland

16. Informant: Mrs. Urner Buser
Address: 107½ Blaul Ave. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 25, 1940 (month) (day) (year)
Cemetery or crematory: Odd Fellowes Cem.
Location: Near Flintstone

18. Funeral director: J. C. Wolford
Address: Cumberland, Md.

19. June 24 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22, 1940 (M)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1940, to June 22 1940, and that I last saw him alive on June 21 1940.

Immediate cause of death: Cancer of Stomach — DURATION: 6 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Ot operations:
Ot autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury — Injured at work?

23. SIGNATURE: P. C. Barnes M.D.
M. D. or other
Address: Cumberland, Md. Date signed: 6-24-40

RECEIVED
JUL 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (8)

Reg. Dist. No. 9

# CERTIFICATE OF DEATH

06107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

**1. PLACE OF DEATH:**

(a) County Allegany

(b) City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Miners Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of atay in this community (yrs., mos., or days) 0

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State Md. (b) County Allegany.

(c) City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. Miners Hospital
(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Infant Burkett (Still-born).

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Stillborn

6 (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceaaed (mo., day, yr.) June 11, 1940.

8. **AGE:** Years | Months | Days | If less than one day: Stillborn | _____ hr. _____ min.

9. Birthplace Frostburg, Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business —

**FATHER**

12. Name Wm Carl Burkett

13. Birthplace Vale Summit, Md.

**MOTHER**

14. Maiden Name Ethel Berry.

15. Birthplace Vale Summit Md.

16 (a) Informant Mrs. Carl Burkett

(b) Address Frostburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13 1940 (month) (day) (year)

(c) Cemetery or crematory Eckhart Cem.

Location Eckhart mines, Md.

18 (a) Funeral director Wm Carl Burkett

(b) Address 125 Mt. Pleasant St. Frostburg Md

19 (a) 6-13 1940 (Date rec'd by registrar) (b) mrs. A. R. Hartley Registrar

## MEDICAL CERTIFICATION

20. Date of death June 11 1940, at 9:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____, and that I last saw him alive on _____ 19____.

| Immediate cause of death | Duration |
|---|---|
| Still born. | |
| Due to Premature Separation of Placenta | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ (Specify type of place) While at work? _____

(e) Means of injury _____

23. **Signature** H. C. Diehl M. D.
M. D. or other

Address Frostburg, Md Date aigned 6/12/40

RECEIVED
JUL 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS 8293

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63b

06108

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland,
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 879 Patterson Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 4 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 879 Patterson Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lillie Butler,

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife G.C.Butler

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1912

8. AGE: Years 27 Months 8 Days 3 If less than one day hrs. min.

9. Birthplace Elkins ,W.Va.
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Tom Manroe
13. Birthplace Do not know.

MOTHER
14. Maiden name Delia Chenoweth,
15. Birthplace Elkins ,W.Va.

16. Informant Grover C.Butler,
Address 879 Patterson Ave.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 2,1940 (month) (day) (year)

Cemetery or crematory Queens Point Cemetery

Location Keyser, W.Va.

18. Funeral director B.W.Markwood.
Address Keyser, W.Va.

19. July 1, 1940 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 30,1940 19 11.55 P M at

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from June 10 1940, to June 30 1940, and that I last saw him alive on June 30 1940.

| Immediate cause of death | DURATION |
|---|---|
| Acute Dilatation of Heart | 2 days |
| Due to Acute Endocarditis and Myocarditis | 2 mos |
| Due to Hyperthyroidism | 2 mos |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. Alan G. Hennegard M.D. or other

Address 41 Green Ed Cumberland Md Date signed July 1 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-B)

06109

# CERTIFICATE OF DEATH

Reg. Dist. No. 10

**1. PLACE OF DEATH:**
County: Allegany
City or town: Mt Savage
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Mt Savage Road
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): 36 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Mt Savage Road
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Thomas Benton Cessna

**3. (b) Social Security Number**

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: Married
B (b) Name of ~~husband or~~ wife: Emma Cessna
6(c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): 7/10/1861
8. AGE: Years 78 Months 11 Days 1 If less than one day ___ hrs. ___ min.
9. Birthplace: Centerville Pa (Town, county, and state)
10. Usual occupation: Butcher
11. Industry or business: Meat Market
FATHER 12. Name: Jacob Cessna
13. Birthplace: Bedford Pa
MOTHER 14. Maiden name: Mary Kreighbaum
15. Birthplace: Bedford Pa
16. Informant: Miss Helen Cessna
Address: Mt Savage Md
17. Burial (Burial, cremation, or removal, Which?) Date thereof 6/13/40 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Centerville Pa
18. Funeral director: William H. Kight
Address: Cumberland Md
19. 6/12 1940 (Date rec'd by registrar) H. J. Bostetter M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1940, at 5 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1940, to June 11 1940, and that I last saw him alive on June 10 1940.

| Immediate cause of death | DURATION |
|---|---|
| Uraemia | 10 days |
| Due to Chronic Nephritis | |
| Due to Carcinoma Prostate | 6 mos |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Alan G. Murray M.D. M. D. or other
Address: 41 Green St Cumberland Date signed June 11 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T) (N) (M)

1454

RECEIVED
JUL 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt. Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Church Hill
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Emma Burall Church

**3. (b) Social Security Number:** None

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Charles L. Church

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 15 - 1878

8. AGE: Years: 61 Months: 8 Days: 11 If less than one day: hrs. min.

9. Birthplace: Mt. Savage - Alleg - Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER 12. Name: George W. Burall

13. Birthplace: Cumberland, Md.

MOTHER 14. Maiden name: Mary C. Rice

15. Birthplace: Sandy Hook, Md.

16. Informant: Maxwell Church

Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28 - 1940 (month) (day) (year)

Cemetery or crematory: St George

Location: Mt Savage, Md.

18. Funeral director: J. J. Durst

Address: Frostburg

19. 6-26-1940 (Date rec'd by registrar)

mrs. A. R. Walker
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1940, at 12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 1940, to June 26 1940, and that I last saw her alive on June 25 1940.

| | DURATION |
|---|---|
| Immediate cause of death: Pulmonary Edema | 3 days |
| Due to: Coronary Thrombosis | 6 wks. |
| Due to: | |
| Other conditions: Generalized edema with ascites. | 4 wks. |

(Include pregnancy within 3 months of death)

Major findings: (ascites)

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. C. Gatten M.D.
M. D. or other

Address: Frostburg, Md. Date signed 6/26/40

RECEIVED
JUL 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

06111

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 4 hrs.

Stay in this community (yrs., or mos., or days) 60 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 300 Park St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME James S. Coniff

3. (b) Social Security Number 705-07-6844

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Haughton

6(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) June 18 1863

8. AGE: Years 77 Months — Days 2 If less than one day ___ hrs. ___ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Engineer (Retired)

11. Industry or business B&O Rrg

FATHER
12. Name James Coniff
13. Birthplace Ireland

MOTHER
14. Maiden name Mary Joseph Tyman
15. Birthplace Ireland

16. Informant Joseph Coniff

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22 '40 (month) (day) (year)

Cemetery or crematory St Patricks Cem.

Location Cumberland

18. Funeral director Louis Stiver Inc.

Address Cumberland

19. June 21, 1940 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 20th., 1940, at 12.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death shock

Due to

Due to

Other conditions Extensive trauma.

(Include pregnancy within 3 months of death)

Major findings:
Of operations (left arm amputated 3 inches below elbow)
Of autopsy none

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide accident Date of 6/19/40

Where did injury occur? Cumberland, Allegany, Maryland.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) R.R.Crossing

Means of injury struck by train Injured at work? no

23. SIGNATURE Pierre H. Larson, M.D.
M. D. or other

Address Date signed

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (S)

## CERTIFICATE OF DEATH

06112

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Oldtown Rt 1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. near Oldtown
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Baby Boy Crabtree

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Child |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1940

8. AGE: Years Months Days If less than one day Stillborn hrs. min.

9. Birthplace Cumberland, Allegany Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Andrew Jackson Crabtree
13. Birthplace Oldtown, Md

MOTHER
14. Maiden name Thelma Leona Wilson
15. Birthplace Oldtown, Md

16. Informant Andrew Jackson Crabtree
Address Oldtown, Md

17. Burial Date thereof June 26, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wilson Cemetery

Location Oldtown, Md.

16. Funeral director Jacob Hafer

Address Cumberland, Md

19. June 26 40 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 23 1940, at 3:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h alive on ____ 19__.

| Immediate cause of death | DURATION |
|---|---|
| Stillborn | |
| Due to Intra uterine asphyxia | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Ot operations

Ot autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Barrow M.D.
M. D. or other

Address 122 Bedford Street Date signed 6/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (146-C) 143C

# CERTIFICATE OF DEATH

06113

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days) 4 days
Stay in this community (yrs., or mos., or days) 43 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Near Oldtown Rt #1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Thelma Leona "Wilson" Crabtree
**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Andrew Jackson Crabtree 6(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) December 30 1901

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | 5 | 23 | hrs. min. |

9. Birthplace Oldtown, Maryland, Alleg Co. (Town, county, and state)
10. Usual occupation Housework
11. Industry or business Own home
FATHER 12. Name George B. Wilson
13. Birthplace Oldtown, Md.
MOTHER 14. Maiden name Addie O. Hamilton
15. Birthplace Oldtown, Md.
16. Informant Andrew J Crabtree
Address Oldtown Md. Rt. #1
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26, 1940 (month) (day) (year)
Cemetery or crematory Wilson Cemetery.
Location Oldtown Md.
18. Funeral director Jacob Hafer
Address Cumberland Md
19 June 26 19 40 J. L. Franklin, M.D. (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 23 19 40, at 2:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1940, to June 23 1940, and that I last saw h alive on June 23 1940.

Immediate cause of death Uterine hemorrhage — DURATION 10 hours
Due to Pregnancy
Due to
Other conditions Hypertension
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. B. Barron M.D.
M. D. or other
Address 122 Bedford St Date signed 6/26/40

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

## CERTIFICATE OF DEATH

06114

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address (hospital, or institution): Sylvan Retreat
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. ~~Sylvan Retreat~~
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR Green Ridge

**3. (a) FULL NAME** Morris Craig

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Unknown |

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1899?

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | | | ____ hrs. ____ min. |

9. Birthplace (Town, county, and state) Unknown

10. Usual occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant Sylvan Retreat
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 3 40 (month) (day) (year)
Cemetery or crematory Allegany County
Location Cumberland Md.

16. Funeral director Louis Stein Inc.
Address Cumberland Md.

19 June 3, 40 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 2 - 1940, at 8 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Time of ad. 19 ____ to 6 - 2 - 1940
and that I last saw him alive on 5 - 28 - 1940

Immediate cause of death Arteriosclerosis — DURATION ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other
Address Cumberland Date signed 6-3-40

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (128)

06115

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State WEST VIRGINIA County PRESTON

City or town TERRA ALTA
(If outside city or town limits, write RURAL and give nearest town)

Street No. 311 WEST STATE ST.,
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME**
MR. CHARLES W. DAVIS

**3.(b) Social Security Number**
None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

6.(b) Name of husband or wife MRS. DESSIE (FEATHER) DAVIS

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 29, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 10 | 19 | hrs. min. |

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation Railway Postal Clerk

11. Industry or business (Retired 1934)

FATHER
12. Name JOSEPH DAVIS
13. Birthplace MAINE

MOTHER
14. Maiden name SARAH GRAHAM
15. Birthplace WEST VIRGINIA

16. Informant MRS. C. W. DAVIS
Address TERRA ALTA, W.VA.

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof June 21, 1940
(month) (day) (year)

Cemetery or crematory Terra Alta Cem.

Location Terra Alta, W.Va.

18. Funeral director A. F. Collins

Address Terra Alta, W.Va.

19. June 20, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

DR. HAWKINS

### MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 18, 1940 19 4:27 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11, 1940, to June 17, 1940 and that I last saw him alive on June 17, 1940

Immediate cause of death: Acute Cholecystitis, Hemorrhagic Pancreatitis

Due to: Double Parotitis

Due to: Parotitis, Pancreatitis

Other conditions

(Include pregnancy within 3 months of death)

DURATION: 10 days

Major findings of operations above.

Date of op. 6/11-40

Autopsy results no.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A H Hawkins
M. D. or other

Address Cumberland, Md. Date signed 6/18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-7)

## CERTIFICATE OF DEATH

06116

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Western Port
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: River Road.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 38 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Western Port. Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: River Road.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Charles Edgar Dellinger

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Anna Bruce Dellinger
6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): November 23, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 6 | 16 | ____ hrs. ____ min. |

9. Birthplace: Middletown, Va. (Town, county, and state)
10. Usual occupation: Dentist
11. Industry or business
FATHER 12. Name: James H. Dellinger
13. Birthplace: Middletown, Va.
MOTHER 14. Maiden name: Anna Crawford Shipley
15. Birthplace: Carroll Co. Md.
16. Informant: Mrs. Anna B. Dellinger
Address: Westernport, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 11 1940 (month) (day) (year)
Cemetery or crematory: Philos Cemetery
Location: Western Port. Md.
18. Funeral director: W. H. Fredlock
Address: Piedmont. W. Va.
19. June 11 1940 (Date rec'd by registrar) Registrar: [illegible]

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: June 8 1940, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 1940, to June 8 1940, and that I last saw him alive on June 8 1940.

| | DURATION |
|---|---|
| Immediate cause of death: Intestional Hemorrhages | 2 Days |
| Due to: Carcinoma of Liver with general Metastasis | 2 Months |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Carcinoma of Liver
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Paul A. Wilson M.D. M. D. or other
Address: Piedmont, W. Va. Date signed: 6-11-40

RECEIVED
JUL 5 1940
BUREAU V. S.

06117 9

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

## CERTIFICATE OF DEATH

Reg. Dist. No.

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 25 Broadway

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 25 Broadway (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Infant — Donahue (Stillborn)

**3. (b) Social Security Number**

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife: —

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 25-1940

8. AGE: Years: stillborn | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace: Frostburg-Alleg-Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER: 12. Name: Joseph Donahue

13. Birthplace: Huffman, Md.

MOTHER: 14. Maiden name: Margret Lucas

15. Birthplace: Carlos, Md.

16. Informant: Joseph Donahue

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 25-1940 (month) (day) (year)

Cemetery or crematory: St Michaels

Location: Frostburg

18. Funeral director: Fisher Joe Donahue ~~R J Dunst~~

Address: Frostburg, Md

19. 6-25 1940 (Date rec'd by registrar) Mrs. A. R. Walker, Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 1940, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Stillborn — Toxemia of pregnancy — acute nephritis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. (M. D. or other)

Address: Frostburg, Md. Date signed: 6/25/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 3 1940
BUREAU V

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06118

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany County

City or town: Cumberland, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: LaVale

(If rural, give LOCATION)

2.(a) If veteran, name war: NO

**3.(a) FULL NAME:** WILLIAM H. DUCKWORTH

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widower |

6.(b) Name of husband or wife: Julia Doman

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 5, 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 0 | 8 | ..... hrs. ..... min. |

9. Birthplace: Maryland Lonaconing (Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: LaVale School House

FATHER — 12. Name: Aaron Duckworth

FATHER — 13. Birthplace: Maryland Lonaconing

MOTHER — 14. Maiden name: Rebecca Greenway

MOTHER — 15. Birthplace: W Va.

16. Informant: Memorial Hospital

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15, 1940 (month) (day) (year)

Cemetery or crematory: Hillcrest

Location: Cumberland

18. Funeral director: Jones Bros.

Address: Cumberland

19. June 15 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: June 13, 1940 at 7:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1940, to June 13, 1940 and that I last saw h[illegible] alive on June 12, 1940

| Immediate cause of death | DURATION |
|---|---|
| Generalized Arteriosclerosis | |
| Cardiac Myocarditis | |
| Due to Senility | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Clark R. Durrett M. D. or other

Address: Cumberland Date signed: June 17, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. DURRETT

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (81)

## CERTIFICATE OF DEATH

06119

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 3 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: W. Va. County: Hampshire

City or town: Romney

(If outside city or town limits, write RURAL and give nearest town)

Street No. River Route

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3.(a) FULL NAME**

MRS. ANNA CORBIN EVANS

**3.(b) Social Security Number**

None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: John William Evans

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): 1893

8. AGE: Years: 47 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Oscar Corbin

13. Birthplace: West Virginia

MOTHER

14. Maiden name: Lutitia ? ?

15. Birthplace: West Virginia

16. Informant: J. W. Evans.

Address: Romney. W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10-1940 (month) (day) (year)

Cemetery or crematory: St Luke

Location: Romney. W. Va.

18. Funeral director: C. THRUSH'S.

Address: ROMNEY, W.VA.

19. June 10 1940 J. L. Franklin, M.D. (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: June 8 1940, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1940 to June 8 1940 and that I last saw h[illegible] alive on June 8 1940

Immediate cause of death: Pneumococci Meningitis

DURATION: ?

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. L. Williams M. D. — other

Address: Cumberland Date signed: 6-8-40

RECEIVED
JUL 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122-B

# CERTIFICATE OF DEATH

Reg. Dist. No. 8 — 06120

**1. PLACE OF DEATH:**

County: Allegany

City or town: Midland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 5½ Months

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: West Virginia — County: Mineral

City or town: Elk Garden — Ward No.: —
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

**3. (a) FULL NAME:** Mary E. Elsie Evans

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife: Otho Evans

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 29 1874

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 2 | 17 | ____ hrs. ____ min. |

9. Birthplace: Middland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: House Work

11. Industry or business: Home

FATHER — 12. Name: Harry Elsie

FATHER — 13. Birthplace: Va. Summit, Md.

MOTHER — 14. Maiden name: Matilda Stevenson

MOTHER — 15. Birthplace: Unknown

16. Informant: Mrs. Agnes Sherwood

Address: Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 19 1940 (month) (day) (year)

Cemetery or crematory: Elk Garden Cemetery

Location: Elk Garden, W. Va.

18. Funeral director: W. Eichhorn

Address: Lonaconing, Md.

19. June 19 1940 E. Don Taylor
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1940, at 7:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1940, to June 16 1940, and that I last saw h[illegible] alive on June 16 1940.

Immediate cause of death: Intestinal Obstruction — DURATION: —

Due to: Peritonitis (Post Operative)

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings:

Ot operations: —

Ot autopsy: —

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?): —

Means of Injury — Injured at work?

23. SIGNATURE: R. M. Shelton Jr. M.D.
M. D. or other

Address: Midland, Md. — Date signed: 6-18-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 6 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

WITHIN CORPORATE LIMITS

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 94 Broadway

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** James H. Fuller

**3. (b) Social Security Number:** None

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Alice Fuller

6(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): July 12-1862

8. AGE: Years: 78 Months: 11 Days: 1 If less than one day: hrs. min.

9. Birthplace: Frostburg - Alleg - Md.

(Town, county, and state)

10. Usual occupation: bricklayer

11. Industry or business:

FATHER 12. Name: James Fuller

13. Birthplace: Brownsville, Pa.

MOTHER 14. Maiden name: Anna Worsing

15. Birthplace: Addison, Pa.

16. Informant: Samuel Fuller

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15-1940 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg

18. Funeral director: J. J. Dugan

Address: Frostburg, Md.

19. 6-15 1940 (Date rec'd by registrar) mo. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13 1940, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936 to June 13 1940, and that I last saw him alive on June 13 1940.

Immediate cause of death: Arteriosclerosis — DURATION: 7

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane Jr. M.D. M. D. or other

Address: Frostburg Md Date signed 6-15-40

RECEIVED
JUL 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48a)

# CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS 6122 9

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-415

**1. PLACE OF DEATH:**

County Allegany

City or town Frostburg, Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 wk

Stay in this community (yrs., or mos., or days) 20 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Estelle Virginia Talloray

**3. (b) Social Security Number** None

4. Sex: Female

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jos. Talloray

6(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Apr. 12 — 1877

8. AGE: Years 63 | Months ~~2~~ | Days 17 | If less than one day: hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Eckstant Nurse

11. Industry or business: Housewife

FATHER 12. Name: Don't know

13. Birthplace: " "

MOTHER 14. Maiden name: Don't know

15. Birthplace: " "

16. Informant: Mrs Susan Randolph

Address: 98 Chestnut St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1 1940 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg Md

18. Funeral director: Jacobs & Wafer

Address: Frost Burg Md

19. July 14 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1940 19 , at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1940, to June 24 1940, and that I last saw h alive on June 24 19 40.

| | DURATION |
|---|---|
| Immediate cause of death: Bronchopneumonia | |
| Due to Carcinoma of cervix metastasis to brain | |
| Due to Contusion | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN** Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. Eaclefuss M. D. or other

Address 66 W Main St Frostburg Md Date signed 8-1-40

RECEIVED
JUL 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

06123

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland,
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or insf. (yrs., or mos., or days) 7 hrs.

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 162 Bedford St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Baby Boy George

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Infant |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 23. 1940

**8. AGE:** Years | Months | Days | If less than one day 7 hrs. min.

9. Birthplace Cumberland, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Jack P. George
13. Birthplace Maryland

MOTHER
14. Maiden name Eugenia Cauffman
15. Birthplace Maryland

16. Informant Ella M Hartwangler

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24, 1940 (month) (day) (year)

Cemetery or crematory Madley Cemetery

Location Madley, Pa.

18. Funeral director Harvey H. Zeigler

Address Hyndman, Pa.

19. June 24 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 23 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 1940, to June 23 1940, and that I last saw him alive on June 23 1940.

Immediate cause of death Atelectasis

DURATION

Due to Premature Birth (7 mths)

Due to Premature Seperation of Placenta.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Oowhead, M. D.
M. D. or other

Address 41 Green St. Cumberland Md. Date signed 6/24/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 8 1940
BUREAU V. S

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

## CERTIFICATE OF DEATH

06124

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 819 Gephart Drive.
Stay in hospital or inst. (yrs., or mos., or days) 63 yrs.
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Allegany.
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 819 Gephart Drive.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Mary Booth Gloss.

**3. (b) Social Security Number** none

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Cyphas H. Gloss
6(c) If alive, give age: 68 years
7. Birth date of deceased (mo., day, yr.): Feb 16 1877
8. AGE: Years: 63 Months: 3 Days: 17 If less than one day: hrs. min.
9. Birthplace: Cumberland (Town, county, and state) Md.
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Thomas Foster
13. Birthplace: England.
MOTHER 14. Maiden name: Elizabeth Booth
15. Birthplace: England.
16. Informant: Cyphas Gloss.
Address: Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5, '40 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland Md.
18. Funeral director: Louis Stein Inc.
Address: Cumberland
19. June 5 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: 6/3 1940, at 8 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Had not 19, to 19, and that I last saw h alive on Had not 19.

| | DURATION |
|---|---|
| Immediate cause of death: Coronary Occlusion | 6/3/40 |
| Due to: Myocarditis | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. W. Mosser Jr. M. D. or other
Address: Cumberland Date signed 6/4/40

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

06125

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-D)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution 813 Columbia Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 45 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 813 Columbia Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No.

**3. (a) FULL NAME** Samuel Isaac Gormer

**3. (b) Social Security Number** None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6(b) Name of husband or wife Emma Margaret Heller Gormer

6(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Apr. 3, 1883

**8. AGE:** Years 57 Months 2 Days 11 If less than one day ___ hrs. ___ min.

9. Birthplace Carbonsville Md (Town, county, and state)

10. Usual occupation Fireman

11. Industry or business City Fire Department

FATHER

12. Name Isaac Gormer

13. Birthplace Carbonsville, Md

MOTHER

14. Maiden name Anna Foy

15. Birthplace Not Known

16. Informant Emma Gormer

Address 813 Columbia Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16, 1940 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland

18. Funeral director Jacob Safer

Address Cumberland

19. June 15 1940 J. P. Franklin, M.D. (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1940, at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-3-40 19__, to 6-14-1940 and that I last saw him alive on 6-13-1940

Immediate cause of death Carcinoma of Lung

DURATION ?

Due to

Due to

Other conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings:

Df operations

Df autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. L. Williams M. D. or other

Address Cumberland Date signed 6/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

## CERTIFICATE OF DEATH

06126

Reg. Dist. No. 4

**1. PLACE OF DEATH**

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 606 Virginia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Mary Edith Gross

**3.(b) Social Security Number** 26th None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | married |

6.(b) Name of husband or wife John J. Gross

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 3 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 11 | 8 | ..... hrs. ..... min. |

9. Birthplace Cumberland Md.

(Town, county, and state)

10. Usual occupation Home

11. Industry or business

FATHER 12. Name Geo Rice

13. Birthplace Md.

MOTHER 14. Maiden name Sarah Allen - Conners

15. Birthplace Buckhannon W. Va.

16. Informant Mr John J Gross

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 29 40 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland Md

18. Funeral director Louis Steinbrun

Address Cumberland Md

19. June 28 1940 J. P. Franklin M.D. (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 26 1940 at 12 35 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

| | DURATION |
|---|---|
| Immediate cause of death Cerebral Hemorrhage | |
| | |
| Due to | |
| | |
| Due to | |
| | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lewis H. Bowen M.D.

M. D. or other

Address Cumberland Md Date signed 6/27/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

## CERTIFICATE OF DEATH

06127

Reg. Diat. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 5 yrs.

Hospital, Institution, or street address where death occurred: 751 S. Mechanic St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 751 S. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Martin William Himmler

**3.(b) Social Security Number:** 220-10-0879

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6.(b) Name of husband or wife: Ella Gray Baker

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): May 1875

**8. AGE:** Years: 65 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Mechanic.

11. Industry or business

FATHER — 12. Name: Henry Himmler

FATHER — 13. Birthplace: Cumberland Md

MOTHER — 14. Maiden name: Leopoldina Filinger

MOTHER — 15. Birthplace: Germany.

16. Informant: Mrs Lerta Gross.

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28 40 (month) (day) (year)

Cemetery or crematory: St. Luke's Cem.

Location: Cumberland

16. Funeral director: Louis Stein Inc

Address: Cumberland.

19. June 28 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1940, at 5:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14, 1940 to June 26, 1940 and that I last saw him alive on June 26, 1940

| Immediate cause of death | DURATION |
|---|---|
| Apoplexy — | 12 days |
| Due to: ? | |
| Due to: | |
| Other conditions: None | |

(Include pregnancy within 3 months of death)

Major findings of operations: No —

Date of op.

Autopsy results: No —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address 65 S. Centre St. Date signed 6/27/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

06128

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Flintstone Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Baby Girl Imes

**3. (b) Social Security Number**

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1940

**8. AGE:** Years | Months | Days | If less than one day: 14 hrs. 50 min.

9. Birthplace Cumberland, Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER: 12. Name Thomas A. Imes

13. Birthplace Rainsburg Pa

MOTHER: 14. Maiden name Lottie Marie Fletcher

15. Birthplace Piney Grove Md.

16. Informant Thos. A. Imes

Address Flintstone Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13, 1940 (month) (day) (year)

Cemetery or crematory Glendale Cem

Location Flintstone Md

18. Funeral director Thos. A. Imes

Address Flintstone Md

19. June 13 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1940, at 5 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1940, to June 13 1940, and that I last saw her alive on June 12 1940.

Immediate cause of death: Prematurity (6 mo gestation)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or other

Address 40 N. Liberty St. Date signed 6-14-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

# CERTIFICATE OF DEATH

06129

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Rural near Mt. Savage.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md County Allegany

City or town Rural near Mt. Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rosella E. Imes.

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Child.

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1939

8. AGE: Years ~~10~~ Months 10 Days 25 If less than one day hrs. min.

9. Birthplace Mt. Savage, Allegany, Md.
(Town, county, and state)

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Thomas F. Imes
13. Birthplace Mt. Savage.

MOTHER
14. Maiden name Viola R. Gordon
15. Birthplace Mt. Savage

16. Informant Thomas F. Imes.
Address Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 7, 1940. (month) (day) (year)

Cemetery or crematory Gordon Cemetery.

Location Near Mt. Savage.

18. Funeral director Jacob Hafer
Address Cumberland, Md.

19. 6/8 1940 H. J. Bostetter MD Registrar
(Date rec'd by registrar)

Dr. C. E. Owens

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1940, at 7 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27th 1940, to May 27 1940, and that I last saw her alive on May 27 1940.

Immediate cause of death

Due to Acute Bronchos Pneumonia

Due to The bronchopneumonia was primary. There was no associated disease. C.W.G.R.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 3 hrs

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. E. Owens MD
M. D. or other

Address Cumberland Md Date signed 12-6-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (147-B)

06130

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md. County Garrett

City or town Oakland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 79 Third St.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Jackson Gwendolyn Mrs.

**3. (b) Social Security Number** None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: John H. Jackson

6.(c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) July 17, 1914

**8. AGE:** Years 25 Months 11 Days 26 If less than one day ..... hrs. ..... min.

9. Birthplace West Virginia, Spencer (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Ourchome

FATHER 12. Name O. R. Hardman

13. Birthplace West Virginia

MOTHER 14. Maiden name Grace Hollswade

15. Birthplace West Virginia

16. Informant J. H. Jackson

Address 79 Third St., Oakland, Md

17. Removal (Burial, cremation, or removal, which?) Date thereof June 16, 1940 (month) (day) (year)

Cemetery or crematory Spencer Cem

Location Spencer, W. Va

18. Funeral director M. Eichhorn

Address Lonaconing, Md

19. June 13, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 - 1940, at 4 10 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1940, to June 13 1940 and that I last saw her alive on June 13/40 19

Immediate cause of death: Pregnancy 8 month Placenta Praevia

Due to

Due to

Other conditions: Puerperal septicemia Bronchio Pneumonia (Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Placenta Previa Preg. 8 mo. Date of op. June 1/40

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Knight Reynolds M.D. M. D. or other

Address Cumberland Md Date signed June 13/40

Dr. Reynolds.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (170-c)

06131

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County Allegany
City or town Rural Near Cumberland.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Braddock Road.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Allegany.
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 406 Beall St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Richard Toll Jenkins
3. (b) Social Security Number 214-07-2568

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Married.
6 (b) Name of husband or wife Elsie Moore
6(c) If alive, give age 29 years
7. Birth date of deceased (mo., day, yr.) June 5, 1908
8. AGE: Years 32 Months 0 Days 15 If less than one day hrs. min.
9. Birthplace Gilmore Allegany, Md.
(Town, county, and state)
10. Usual occupation Assist Foreman
11. Industry or business Celanese - Textile
FATHER 12. Name Joseph Henry Jenkins
13. Birthplace Midland Md
MOTHER 14. Maiden name Elizabeth Toll
15. Birthplace Midland Md.
16. Informant Isabelle Nightingale
Address Gills Hill - Lonaconing Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23, 1940 (month) (day) (year)
Cemetery or crematory Allegany
Location Frostburg Md
18. Funeral director Jacob Hafer
Address Cumberland Md
19. June 21 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 20th., 1940, at 6.10 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19
Immediate cause of death Fractured skull
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy none

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 6/20/40
Where did injury occur? Near Cumberland, Allegany, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury auto accident Injured at work? no

23. SIGNATURE Lucius H. Corson M.D.
M. D. or other
Address Cumberland, Maryland. Date signed 6/20/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

## CERTIFICATE OF DEATH

06132

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: 160 Union St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 50 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 160 Union St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** William Jones.

**3. (b) Social Security Number** none.

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Widowed |

6 (b) Name of husband or wife Lavina Taylor
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1860

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | | | hrs. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Barber retired 10 yrs

11. Industry or business

FATHER
12. Name Lewis Jones.
13. Birthplace ?

MOTHER
14. Maiden name Unknown.
15. Birthplace

16. Informant Friends.
Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6 1940 (month) (day) (year)
Cemetery or crematory Summit View.
Location Cumberland Md.

18. Funeral director Lewis Stein Sons
Address Cumberland.

19. June 6 1940 J. L. Hankins, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 4th 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20th 1940, to June 4th 1940, and that I last saw him alive on June 3rd 1940.

Immediate cause of death Cardiac degeneration — DURATION 4 hrs

Due to Old Age.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE J. J. Langston, M.D.
M. D. or other
Address 54 N. Mechanic St. Date signed 6-5-40

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JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46B)

06133

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 211 Wallace St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 211 Wallace St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Edward Jordan.

3. (b) Social Security Number 705-05-5272

4. Sex Male

5. Color or race Colored

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1877

8. AGE: Years about 63 | Months | Days | If less than one day hrs. min.

9. Birthplace Paw Paw W. Va.

(Town, county, and state)

10. Usual occupation Porter

11. Industry or business B + O Ry.

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Unknown.

15. Birthplace

16. Informant Mrs Nellie Ashby.

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 '40 (month) (day) (year)

Cemetery or crematory Sumner Cem.

Location Cumberland Md.

16. Funeral director Louis Stein Inc.

Address Cumberland.

19. June 12, 1940 (Date rec'd by registrar) J. P. Franklin M. D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1940, at 7:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1939, to June 8 1940 and that I last saw him alive on June 8, 1940.

Immediate cause of death Edema of Lung

Due to Carcinoma of Stomach

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations Carcinoma of Stomach

Of autopsy —

DURATION 1 Day About one Year

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE George C. Hollomand M.D. M. D. or other

Address 145 Hanover St. Date signed 6-10-40

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

06134

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-c)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: allegany

City or town: Cumberland - [illegible]
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: md County: allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Ridgeway Terrace
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** John Henry Kaine

**3. (b) Social Security Number:** 214-07-5317

4. Sex: m

5. Color or race: w

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edith Kaine

6(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): Dec. 11 - 1908

8. AGE: Years 31 | Months 6 | Days 9 | If less than one day ___ hrs. ___ min.

9. Birthplace: Vale Summit - alleg - md
(Town, county, and state)

10. Usual occupation: silk worker

11. Industry or business: Celanese

FATHER
12. Name: James H. Kaine
13. Birthplace: Vale Summit

MOTHER
14. Maiden name: Annie Leak
15. Birthplace: Vale Summit md.

16. Informant: Leonard Kaine
Address: Frostburg, md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: June 24-1940 (month) (day) (year)

Cemetery or crematory: St Michaels

Location: Frostburg, md.

18. Funeral director: J J Durst
Address: Frostburg, md.

19. June 22 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20th., 1940, at 8.15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death: Fractured skull

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: none

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 6/20/40

Where did injury occur? near Cumberland, Allegany, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Highway

Means of injury: auto accident Injured at work? no

23. SIGNATURE: Lionel H. Corson, M.D.
M. D. or other

Address: Cumberland, Md. Date signed: 6/20/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

# CERTIFICATE OF DEATH

06135

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Eckhart md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State md County allegany

City or town Eckhart, md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Mary A. Kirby

**3. (b) Social Security Number** None

4. Sex F | 5. Color or race W | 6.(a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Wm C. Kirby

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9-1877

8. AGE: Years 63 | Months 7 | Days 7 | If less than one day hrs. min.

9. Birthplace Frostburg - alleg - md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Robt. Wafak

13. Birthplace England

MOTHER 14. Maiden name Elizabeth Atkinson

15. Birthplace Frostburg, md.

16. Informant Wm Kirby

Address Eckhart, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14-1940 (month) (day) (year)

Cemetery or crematory St. Michaels

Location Frostburg, md.

18. Funeral director J. J. Dugan

Address Frostburg

19. June 14 1940 (Date rec'd by registrar) Mrs. A. R. Hooker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1940, at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1940, to June 11 1940, and that I last saw h-m alive on June 11 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebro-vascular Accident | |
| Due to Hypertension & Hypertensive Heart | |
| Due to Cancer | |
| | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. Earle
M. D. or other

Address 6 N W Main St Date signed 6-13-40

Frostburg Md

RECEIVED
JUL 3 1940
BUREAU V

06136

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (58)

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Grahamtown, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs 6 ms

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Grahamtown Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Irma Elizabeth Kroll

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Child |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 24 — 1924

**8. AGE:** Years 11 | Months 5 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Grahamtown, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name Conrade C. Kroll

13. Birthplace Frostburg, Md.

MOTHER — 14. Maiden name Edith Pinther

15. Birthplace Cumberland, Md.

16. Informant Conrade C. Kroll

Address Grahamtown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6 — 17 — 40 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Daniel [illegible]

Address Frostburg, Md.

19. 6 — 17 1940 (Date rec'd by registrar) Mrs. A. R. Tucker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1940, at 10 A M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from April 10 1940, to June 15 1940

and that I last saw h.. alive on June 15 1940

| Immediate cause of death | DURATION |
|---|---|
| Subacute Bacterial Endocarditis | |
| Due to Acute Tonsillitis | |
| Due to Rheumatic Fever | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address [illegible] Date signed 6-18-40

Frostburg Md.

RECEIVED
JUL 8 1940

Outside of City Limits

(M)

MARGIN RESERVED FOR BINDING

(I)

(T)

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170c)

06137

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Rural Near Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution Braddock Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 5 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1012 Rolling Mills Place

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Margaret Gertrude Lear

**3. (b) Social Security Number** 220-07-6140

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife John L Lear

6(c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Mar 24, 1912

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 28 | 2 | 26 | hrs. min. |

9. Birthplace Hamilton W. Va.
(Town, county, and state)

10. Usual occupation Waitress

11. Industry or business Restaurant

FATHER 12. Name Robert Sturgis

13. Birthplace Philippi W Va.

MOTHER 14. Maiden name Evelyn Daft

15. Birthplace Buttonsville W Va

16. Informant Miss Florence Sterns

Address Hamilton, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24, 1940 (month) (day) (year)

Cemetery or crematory Goff Cem.

Location Hamilton W. Va.

18. Funeral director Jacob Hafer

Address Cumberland, Md.

19 June 22 1940 J. L. Franklin, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 20th., 1940, at 6.10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

| Immediate cause of death | Fractured skull | DURATION |
|---|---|---|
| Due to | | |
| Due to | | |
| Other conditions | | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy none

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6/20/40

Where did injury occur? near Cumberland, Allegany, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury auto accident Injured at work? no

23. SIGNATURE Prince H. Larson M.D.
M. D. or other

Address Cumberland, Maryland, Date signed 6/22/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-C)

## CERTIFICATE OF DEATH

06138

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One day

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? One day

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Shallmar
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME**

LECHLITER, BABY GIRL

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 23, 1940

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | ..... hrs. ..... min. |

9. Birthplace: Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Newborn infant

11. Industry or business

FATHER
12. Name: Donald Monroe Lechliter
13. Birthplace: Maryland

MOTHER
14. Maiden name: Edith Louise Dawson
15. Birthplace: Maryland

16. Informant: Mrs. Donald Lechliter

Address: Shallmar, Md.

17. Burial, cremation, or removal. Which?: Removal — Date thereof: June 26 1940 (month) (day) (year)

Cemetery or crematory: I. O. O. F. Cem.

Location: Elk Garden, W. Va.

18. Funeral director: O. F. Sharpless

Address: Blaine, W. Va.

19. June 25 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: June 24, 1940, at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 1940, to June 24 1940

and that I last saw her alive on June 24 1940

| Immediate cause of death | DURATION |
|---|---|
| | |
| Due to: Cyanosis of undetermined origin | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Nothing abnormal except hyaline membrane disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arthur J. Jones M.D.
M. D. or other

Address: 40 N. Liberty St. Date signed: 6-25-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

06139

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 314 Broadway
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Patricia Ann Infant Leighty

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 25 1940

**8. AGE:** Years | Months | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland, Allegany Co Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Ray Cleveland Leighty
13. Birthplace Mt Savage Md.

MOTHER
14. Maiden name Bernetta F Keller
15. Birthplace W. Va.

16. Informant Ray C Leighty
Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28 '40 (month) (day) (year)

Cemetery or crematory Methodist Cem.

Location Mt Savage Md

18. Funeral director Louis Stein Inc
Address Cumberland

19. June 29 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1940 at 1.30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1940, to June 27 1940 and that I last saw him alive on June 26 1940

Immediate cause of death Premature Infant 7 mos

Due to Acute Nephritis

Due to Uraemia in mother 3 wks

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M.D. (M.D. or other)

Address 41 Grove St Cumberland Md Date signed June 28 40

VS A15 (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

061140

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 dy

Stay in this community (yrs., or mos., or days) 2 da

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md County Allegany

City or town Keyser R.F.D. #2 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. / (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Baby Boy Lewis

**3. (b) Social Security Number** none

4. Sex M | 5. Color or race W | 6.(a) Single, married, widowed, or divorced

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Oliver G. Lewis

13. Birthplace Frostburg Md

MOTHER 14. Maiden name Dove Tallman

15. Birthplace Upshur Co. W Va.

16. Informant O. G. Lewis

Address Georgetown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14 1940 (month) (day) (year)

Cemetery or crematory Allegany Cem

Location Frostburg Md.

18. Funeral director Jacob Bolyes

Address Cumberland

19 June 14 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 13th 1940, at 8:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1940, to June 13 1940, and that I last saw him alive on June 13 1940.

| | DURATION |
|---|---|
| Immediate cause of death Premature birth | |
| Due to Maternal Acute Nephritis | 2 wks |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. Alan E. Murray MD
M. D. or other

Address 41 Green St Date signed June 14 1940

RECEIVED
JUL 8 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

## CERTIFICATE OF DEATH

06741

Reg. Dist. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Little Orleans (Rural near)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: R.F.D. 1

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 26 — life

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Little Orleans (Rural near) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.F.D. 1.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Mann

**3. (b) Social Security Number:**

4. Not determinable

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 23, 1940

8. AGE: Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Little Orleans R.F.D. Allegany Co. Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Homer H. Mann

FATHER 13. Birthplace: McKeesport, Pa

MOTHER 14. Maiden name: Irene H. Price

MOTHER 15. Birthplace: Allegany Co. Md.

16. Informant: Homer H. Mann

Address: R.1. Little Orleans Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 23, 1940 (month) (day) (year)

Cemetery or crematory: at the home

Location: Little Orleans, Md. R.1.

18. Funeral director: Homer H. Mann

Address: Little Orleans, Md. R1.

19. June 24 1940 (Date rec'd by registrar) T.T. Mann (Per) M.E. Mann Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23 1940, at 8a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

| Immediate cause of death | DURATION |
|---|---|
| Still born | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. A. Watson M. D. or other

Address: Little Orleans, Md. Date signed: June 23, 1940

RECEIVED
JUL 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

06142

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(46E)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 49 days.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MD. County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. MICHIGAN AVE., MAPLESIDE.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**
FRANCES, MANTHEIY

**3. (b) Social Security Number**
None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | MARRIED |

6.(b) Name of husband or wife JOHN MANTHEIY

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) March, 18, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 3 | 12 | hrs. min. |

9. Birthplace WASHINGTON, D. C.
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant John Manthey
Address Cumberland

17. Burial Date thereof July 3 '40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sts Peter & Pauls Cem

Location Cumberland

18. Funeral director Louis Stein Inc
Address Cumberland.

19. July 2 1940 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH JUNE 30, 1940, at 7:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1939, to June 30 1940 and that I last saw her alive on June 29 1940

Immediate cause of death Carcinomatosis

Due to Carcinoma Sigmoid Colon

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. E. Enfield
M. D. or other

Address Cumberland Date signed 7/1/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS

(131-2)

# CERTIFICATE OF DEATH

Reg. Dist. No. 06143

**1. PLACE OF DEATH:**
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 93 Washington St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 93 Washington St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

**3. (a) FULL NAME:** Walter E. Martens

**3. (b) Social Security Number:** None

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Emma Martens
6(c) If alive, give age: 49 years
7. Birth date of deceased (mo., day, yr.): Aug 31 - 1889
8. AGE: Years 50 Months 9 Days 3 If less than one day ___ hrs. ___ min.
9. Birthplace: Mt Savage Md. (Town, county, and state)
10. Usual occupation: Blacksmith
11. Industry or business: Own Shop
FATHER
12. Name: Chris Martens
13. Birthplace: Wellersburg Pa
MOTHER
14. Maiden name: Catherine Rizer
15. Birthplace: Mt Savage Md.
16. Informant: Mrs Walter E. Martens
Address: Frostburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 6 '40 (month) (day) (year)
Cemetery or crematory: Cemetery - Allegany
Location: Frostburg
18. Funeral director: J. J. Hurst
Address: Frostburg, Md.
19. June 6th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 1940, at 12 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 1940, to June 1940, and that I last saw him alive on June 1 1940.

Immediate cause of death: Hypertensive Heart disease Chronic Nephritis — DURATION: 2 years
Due to
Due to
Other conditions: Congestion of liver Gangrene of feet — 5 days
(Include pregnancy within 3 months of death)
Major findings:
Dt operations
Dt autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: F. Alan G. Munn Jr. M.D. (M. D. or other)
Address: 41 Green Co — Date signed: June 4 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

## CERTIFICATE OF DEATH

06144

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, Institution, or street address, where death occurred: Memorial Hospital

How long in hospital or institution? 21 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: N. C. County:

City or town: Greensboro
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME** SAMUEL AARON MARVIS

**3.(b) Social Security Number** 238-12-6749

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widower |

6.(b) Name of husband or wife: Ruth Kaplan

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 22, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 5 | 18 | hrs. min. |

9. Birthplace: Island of Rhodes, Turkey
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business

FATHER 12. Name: Abraham Marvis

FATHER 13. Birthplace: Turkey

MOTHER 14. Maiden name: Sarah Russo

MOTHER 15. Birthplace: Turkey

16. Informant: Memorial Hospital

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 20 40 (month) (day) (year)

Cemetery or crematory: East End Cem.

Location: Cumberland.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. June 19 1940 J. Franklin, M.D. Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10, 1940 at 5:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 25, 1940 to June 10, 1940 and that I last saw him alive on June 10, 1940

| Immediate cause of death | DURATION |
|---|---|
| Generalized Arteriosclerosis | |
| Chronic Myocarditis | |
| & Decompensation | |
| Due to: Right Pleural Effusion | 3/1940 |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Clay E. Durrett M. D. or other

Address: Cumberland, Md. Date signed: June 11, 194-

DR. DURRETT

RECEIVED
JUL 8 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1318) WITHIN CORPORATE LIMITS 9145

## CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Frostburg Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All her life.

Hospital, Institution, or street address where death occurred:

16 Uhl St.

How long in hospital or institution? .....

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Allegany.

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Uhl St.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

**3. (a) FULL NAME** Elizabeth Herwig Mayer.

**3. (b) Social Security Number** None.

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 6, 1864

8. AGE: Years 75 | Months 6 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace Frostburg, Allegany, Md.

(Town, county, and state)

10. Usual occupation House work

11. Industry or business At Home.

FATHER 12. Name John Mayer

13. Birthplace Germany

MOTHER 14. Maiden name Elizabeth Herwig

15. Birthplace Germany

16. Informant Wm. Siegfried.

Address 16 Uhl St Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28 1940 (month) (day) (year)

Cemetery or crematory German Lutheran

Location Frostburg, Md.

18. Funeral director Jacob Hafer.

Address Frostburg, Md.

19. 6-27 1940 mo. A.R. Tucker

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1940, at 11:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1940, to June 25 1940

and that I last saw her alive on June 25 1940

Immediate cause of death ..... DURATION

Chronic nephritis 6 mos.

Chronic myocarditis 6 mos.

Due to arterio-sclerosis 5 yrs.

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H.C. Diehl, M.D.

M. D. or other

Address Frostburg, Md. Date signed 6/27/40

Dr Diehl.

RECEIVED
JUL 3 1940
BUREAU

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

06146

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Ridgley Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 8 Silver St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Catherine Meyers

**3. (b) Social Security Number:** none

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles Meyers

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): [illegible] Jan. 27, 1860

**8. AGE:** Years 80. Months 5 Days 9 If less than one day ____ hrs. ____ min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: at Home.

FATHER
12. Name: Conrad Schiller
13. Birthplace: Germany.

MOTHER
14. Maiden name: Anna M. Kolb
15. Birthplace: Germany

16. Informant: Mrs Elizabeth Gilch
Address: Cumberland.

17. Burial (Burial, cremation, or removal, Which?) Date thereof June 9 40 (month) (day) (year)

Cemetery or crematory: St Lukes Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.
Address: Cumberland.

19. June 8, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 1940, at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1, 1940, to June 6, 1940, and that I last saw her alive on June 6, 1940.

Immediate cause of death: Auricular fibrillation; Arteriosclerosis

DURATION: 2½ mo.; 3 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: D. G. Moore, M.D. M. D. or other

Address: Medical Bldg. Date signed 6/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

## CERTIFICATE OF DEATH

06147

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany.
City or town Cumberland.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 21 Crisap St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 70 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Allegany.
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 21 Crisap St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Teresa Ann Miller

**3. (b) Social Security Number** none

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed. |

6 (b) Name of husband or wife Will B Miller
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 3 1874

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 1 | 15 | ____ hrs. ____ min. |

9. Birthplace W. Va. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Will H. Shaffer.
13. Birthplace W. Va.

MOTHER
14. Maiden name Rosalie McIntyre
15. Birthplace W. Va.

16. Informant Mrs T. B. Shipley
Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20 '40 (month) (day) (year)
Cemetery or crematory Deer Park Md.
Location Deer Park Md.
18. Funeral director Louis Stein Inc.
Address Cumberland

19. June 19, 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June - 18 1940, at 7 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 18 1940, to June - 18 1940, and that I last saw h alive on June 18 1940

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | 1935 |
| Due to Arteriosclerosis | 1930 |
| Due to | |
| Other conditions Diabetes Mellitus | 1920 |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. E. Clemson M.D.
Address 126 Queen St. Cumberland Date signed 6/19/40
M. D. or other

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115-C)

## CERTIFICATE OF DEATH

06148

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 13 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 320 Holland St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: George L. Morris

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 11 1926

8. AGE: Years: 13 Months: 9 Days: 29 If less than one day: hrs. min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER 12. Name: James Morris

13. Birthplace: Frostburg Md

MOTHER 14. Maiden name: Hilda Smith

15. Birthplace: Cumberland Md.

16. Informant: Jas. Morris

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/13/40 (month) (day) (year)

Cemetery or crematory: St Patricks Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. June 12 1940 J. L. Franklin, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1940, at 5 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1940, to June 10 1940, and that I last saw h[illegible] alive on June 10 1940

| Immediate cause of death | DURATION |
|---|---|
| Uremia | |
| Due to Acute Nephritis | 5 wks |
| Due to Tonsillitis | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. C. Bowen M.D.
M. D. or Other

Address: Cumberland Md Date signed 6-11-40

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

06149

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 718 Cumberland St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 40 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland. County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 718 Cumberland St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** James William Murray

**3. (b) Social Security Number** 220-07-6191

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
(b) Name of husband or wife: Mabel B. Athey
(c) If alive, give age: 69 years
7. Birth date of deceased (mo., day, yr.): Sept 17 1868
8. AGE: Years 71 | Months 9 | Days 1 | If less than one day ____ hrs. ____ min.
9. Birthplace: Hancock Md. (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business
FATHER 12. Name: Jas. Patrick Murray
13. Birthplace: Md.
MOTHER 14. Maiden name: Margaret Light
15. Birthplace: Md.
16. Informant: Athey Murray
Address: Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20, '40 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland Md.
18. Funeral director: Lonis Stein Inc
Address: Cumberland
19. June 20 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 18, 1940, at 9.45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25, 1940, to June 18, 1940, and that I last saw him alive on June 18, 1940.

| | DURATION |
|---|---|
| Immediate cause of death Acute Myocarditis | 1 day |
| Due to Hypertention | 2 yrs. |
| Due to ? | |
| Other conditions Prostatic Hypertrophy (Include pregnancy within 3 months of death) | 2 yrs. |

Major findings:
Of operations: None
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE C. C. Zimmerman M.D.
M. D. or other
Address 165 S. Centre St. Cumberland, Md. Date signed 6/19/40

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

DR. ELIASON

06150

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town SWANTON
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(if rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** PAUGH, BABY JOSEPHINE

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | INFANT |

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) APRIL 19, 1940

**8. AGE:** Years | Months 1 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name CHARLES L. PAUGH
13. Birthplace MARYLAND

MOTHER
14. Maiden name BESSIE KITZMILLER
15. Birthplace WEST VIRGINIA

16. Informant BESSIE PAUGH
Address SWANTON, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16 1940 (month) (day) (year)

Cemetery or crematory Mt. Zion

Location 2 Miles North Vindex

18. Funeral director D. S. Boal

Address Westernport Md.

19. June 17 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION** 5:05 A.M.

20. DATE OF DEATH JUNE 15, 1940 19 ... at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 12 1940, to June 15 1940 and that I last saw her alive on June 14 1940

Immediate cause of death Labor Pneumonia Bilateral — DURATION one wk.

Due to

Due to

Other conditions
(include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. W. Eliason M.D. M. D. or other

Address 126 Union St. Cumberland Md. Date signed 6/15/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A-15

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115-C)

# CERTIFICATE OF DEATH

9

06151

Reg. Dist. No. .....

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred: Miner's Hospital

How long in hospital or institution? 4 hours.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany.

City or town: Frostburg.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 Spring St.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

**3. (a) FULL NAME** Robert William Pfaff.

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Child. |

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1934.

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 6 | 5 | 16 | ..... hrs. ..... min. |

9. Birthplace: Frostburg, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Child.

11. Industry or business

FATHER
12. Name: Robert Pfaff.
13. Birthplace: Frostburg, Md.

MOTHER
14. Maiden name: Catherine Quinn.
15. Birthplace: Shaft.

16. Informant: Robert Pfaff.

Address: 113 Spring St., Frostburg, Md.

17. Burial. Date thereof: June 20, 1940.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Eckhart Cemetery

Location: Eckhart, Maryland.

18. Funeral director: Jacob Hafer

Address: Frostburg, Maryland.

19. 6-19 1940 Mrs. A. R. Walker
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1940, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1940, to June 17 1940 and that I last saw him alive on June 17 1940.

Immediate cause of death: Acute Nephritis

Due to: Acute Tonsillitis

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed: 6 [illegible]

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 3 1940
BUREAU

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157a)

06152

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland, rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Corriganville, Md
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Infant Porter

**3. (b) Social Security Number**

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

May 15 1940 6(c) If alive, give age 12 years

7. Birth date of deceased (mo., day, yr.) June 14, 1940

8. AGE: Years | Months | Days | If less than one day 12 hrs. min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

FATHER
12. Name Elmer Porter
13. Birthplace Mt Savage Md

MOTHER
14. Maiden name Hazel Gerlach
15. Birthplace Pa

16. Informant Elmer Porter

Address Corriganville Md

17. White Oak Church Date thereof June 16 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory White Oak Church Pa

Location near Mayersdale Pa

18. Funeral director Gains Stein Inc

Address Cumberland Md

19. June 15 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1940, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1940, to June 15 1940, and that I last saw him alive on June 14 1940.

Immediate cause of death: Congenital Atelectasis, Internal Hydrocephalus

Due to Acute Hydramnios

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur J. Jones M.D.
M. D. or other

Address 40 N. Liberty St. Date signed 6-15-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63a)

06153

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Little Orleans Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Queen E. Potts

**3. (b) Social Security Number:** None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jonas Potts

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): November 13, 1882

8. AGE: Years 58 | Months 7 | Days 14 | If less than one day ____ hrs. ____ min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William Barnes
13. Birthplace: Connecticut

MOTHER
14. Maiden name: Matilda Griffin
15. Birthplace: Canton, Penna.

16. Informant: Omer L. Sellivan
Address: Little Orleans, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 30, 1940 (month) (day) (year)

Cemetery or crematory: Shipley Cem.

Location: Near Little Orleans

18. Funeral director: Ephriam Smith
Address: Artemus, Penna.

19. June 28 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27, 1940, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24, 1940, to June 27, 1940, and that I last saw her alive on June 27, 1940.

Immediate cause of death: Shock and circulatory failure following thyroidectomy for a —

Due to: Primary cause: A large cystic goiter.

Due to: C.W.S.R.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 2 hrs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: C. F. A. Snyder
M. D. or other

Address: Cumberland Md. Date signed: 6-27-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
BUREAU V. S.

06154

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

## CERTIFICATE OF DEATH

Reg. Dist. No. 1

**1. PLACE OF DEATH:**

County: Allegany

City or town: Little Orleans, Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Little Orleans (Rural) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.F.D.1.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Sara E. Price

3. (b) Social Security Number: —

4. Sex: F

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James B. Price

6(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): June

8. AGE: Years: 51 Months: 11 Days: 28 If less than one day: hrs. min.

9. Birthplace: Washington Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home.

FATHER
12. Name: Josephus Norris
13. Birthplace: Washington Co., Md

MOTHER
14. Maiden name: Emma Trail
15. Birthplace: Allegany Co., Md.

16. Informant: James B. Price
Address: Little Orleans Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: June 14, 1940 (month) (day) (year)

Cemetery or crematory: Piney Plains Cemetery

Location: Little Orleans, R.F.D.1.

18. Funeral director: Ephraim Smith
Address: Artemas, Pa.

19. June 12 1940 (Date rec'd by registrar) T. T. Mann (Per) M E Mann Dept Local Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 1940, at 10:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 14 1940, to June 12 1940, and that I last saw her alive on June 12 1940.

Immediate cause of death: Carcinomatosis
Primary in skin, between neck and point of shoulder. [illegible]
Duration: two months; probably longer.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

DURATION: 2 mo. 2 days

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: J. A. Watson
M. D. or other

Address: Little Orleans Md. Date signed: June 12, 1940

VS A15 (T) MARGIN RESERVED FOR BINDING (I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 6 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

WITHIN CORPORATE LIMITS

# CERTIFICATE OF DEATH

Reg. Dist. No. 06155

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Eckhart Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Sarah Pinton Price

**3. (b) Social Security Number:** None

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Owen Price Jr.

6(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): May 29-1867

8. AGE: Years: 73 Months: 0 Days: 5 If less than one day: hrs. min.

9. Birthplace: Eckhart-Alleg-Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER 12. Name: Alexander Goar

13. Birthplace: Scotland

MOTHER 14. Maiden name: Margret Ferguson

15. Birthplace: Scotland

16. Informant: Owen Price, Jr.

Address: Eckhart, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5-1940 (month) (day) (year)

Cemetery or crematory: Eckhart

Location: Eckhart, Md.

18. Funeral director: J. Dunn

Address: Frostburg, Md.

19. 6-4 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1940, 3 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1940, to June 3 1940, and that I last saw her alive on June 2 1940.

| | DURATION |
|---|---|
| Immediate cause of death: Chronic Myocarditis | Several months |
| Due to: moist Gangrene | 1 wk |
| Due to: both legs | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane Jr. M. D. or other

Address: Frostburg Md. Date signed: June 3 1940

RECEIVED
JUL 3 1940
BUREAU

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-C)

## CERTIFICATE OF DEATH

06156

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital.

Stay in hospital or inst. (yrs., or mos., or days) 5 days.

Stay in this community (yrs., or mos., or days) 45 years.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md. County Allegany.

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 509 Central Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Charles Wm. Prince Jr.

**3. (b) Social Security Number** None.

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Bertha Christy

6(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): April 19, 1869

8. AGE: Years: 71 Months: 1 Days: 28 If less than one day: ____ hrs. ____ min.

9. Birthplace: Great Capon, Hampshire, W. Va. (Town, county, and state)

10. Usual occupation: Installing Telephones

11. Industry or business: Telephone Co. (Retired)

FATHER 12. Name: Chas. Wm. Prince, Sr.

13. Birthplace: Luray, Va.

MOTHER 14. Maiden name: Martha Yost

15. Birthplace: Morgan Co., W. Va.

16. Informant: Lewis Alderton

Address: 54 Marion St - Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20, 1940 (month) (day) (year)

Cemetery or crematory: Hill Crest

Location: Cumberland, Md.

18. Funeral director: Jacob Hafer

Address: Cumberland, Md.

19. June 20, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 6-17-40 19____, at 5:18 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1940, to June 17, 1940, and that I last saw him alive on 6-17-40 19____.

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of mouth | 1 yr. |
| Due to 2. | |
| Due to 2. | |
| Other conditions — | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. E. Zimmerman M.D. M. D. or other

Address Date signed

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-C)

## CERTIFICATE OF DEATH

06157

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred:
677 Laing Ave.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 677 Laing Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Charles E. Ralston

213-18-2638 **3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

8.(b) Name of husband or wife Nellie Hanmote
8.(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) April 5 1880

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 2 | 21 | hrs. min. |

9. Birthplace W. Va.
(Town, county, and state)
10. Usual occupation Farmer — W.P.A.
11. Industry or business
FATHER 12. Name Chas E. Ralston
13. Birthplace W. Va.
MOTHER 14. Maiden name Laura Ridgeway
15. Birthplace W. Va.
18. Informant Mrs Chas E. Ralston
Address Cumberland
17. Burial Date thereof June 18 '40
(Burial, cremation, or removal—Which?) (month) (day) (year)
Cemetery or crematory Oldtown Rd.
Location Oldtown Rd
18. Funeral director Louis Stein Sons
Address Cumberland
19. June 20 1940 J. L. Franklin, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 16 1940 3 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1939, to June 16 1940
and that I last saw h.. alive on June 15 1940
Immediate cause of death Decompensation
Due to Angina - Coronaries Cyphilis
Due to
Other conditions

| DURATION |
|---|
| 3 yrs. |

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide W Date of
Where did injury occur? W
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) W
Means of injury Injured at work?

23. SIGNATURE W. G. Blevins M. D. or Other
Address 33 Va Ave Date signed June 21 40

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

## CERTIFICATE OF DEATH

06158

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 26 Bedford St.

Stay in hospital or insl. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 8 years.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State W. Va. County Mineral.

City or town Keyser Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 284 S. Water.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Sarah Susan Hamilton Redman

**3. (b) Social Security Number** None

4. Sex: Female

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife: Charles Redman

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 11, 1861

8. AGE: Years 79 | Months 0 | Days 23 | If less than one day hrs. min.

9. Birthplace: Frankfort - Mineral Co., W. Va.

(Town, county, and state)

10. Usual occupation: House work

11. Industry or business: At Home

FATHER 12. Name: Thomas Hamilton

FATHER 13. Birthplace: Mineral County W. Va

MOTHER 14. Maiden name: Rebecca Duffee

MOTHER 15. Birthplace: Medley, W. Va.

16. Informant: Virginia Brown

Address: 305 Fulmer Ave - Stroudsburg Pa.

17. Burial, cremation, or removal. Which?: Burial Date thereof: June 6, 1940 (month) (day) (year)

Cemetery or crematory: Thorn Rose

Location: Keyser W. Va

18. Funeral director: Jacob Hofer.

Address: Cumberland, Md.

19. June 6, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 4, 1940, at 3.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1940, to June 4 1940, and that I last saw her alive on June 4 1940.

| | DURATION |
|---|---|
| Immediate cause of death: Edema of Lungs | 2 Days |
| Due to: Cerebral Hemorrhage | 3 Days |
| Due to: | |
| Other conditions: — | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE George C. Hollenbeck M.D.

M. D. or other

Address 140 F Harrison St. Date signed June 6 1940

RECEIVED
JUL 8 1940
BUREAU V. S

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (468)

06159

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One week

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? One week

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Pennsylvania County: Somerset

City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**

DAISY M. RHOADES

**3. (b) Social Security Number**

None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: John Rhoades

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 18, 1888

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 9 | 29 | ..... hrs. ..... min. |

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Joseph Werner
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Lydia Stahl
15. Birthplace: Pennsylvania

16. Informant: John W. Rhoads
Address: Berlin, Pa.

17. Removal & Burial
(Burial, cremation, or removal. Which?)
Date thereof: June 20 1940
(month) (day) (year)

Cemetery or crematory: Lot of Cemetery

Location: Berlin, Pa.

18. Funeral director: Johnson & Son
Address: Berlin, Pa.

19. June 19 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: JUNE 17, 1940 at 11:15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 10, 1940, to JUNE 17, 1940 and that I last saw her alive on JUNE 17, 1940

Immediate cause of death: Carcinoma

Due to:

Due to: Carcinoma of sigmoid

Other conditions: Ruptured ovarian cyst

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. G. Grace
M. D. or other

Address: Cumberland Date signed: June 18 40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 8 1940
U. S.

WITHIN CORPORATE LIMITS.

34 VA

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-L)

Reg. Dist. No. 4

06160

## CERTIFICATE OF DEATH

**1. PLACE OF DEATH:**

(a) County Allegany

(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 5 Marion St.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State Md. (b) County Allegany

(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(d) Street No. 5 Marion St. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Richard C. Rice

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary A. Rice

6. (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1867

8. AGE: Years 73 | Months 5 | Days 4 | If less than one day ___ hr. ___ min.

9. Birthplace Allegany Co. Maryland (Town, county, and state)

10. Usual occupation Retired Car Builder

11. Industry or business B.&O. R.R. Co.

FATHER

12. Name Thomas B. Rice

13. Birthplace Maryland

MOTHER

14. Maiden Name Rebecca Bucy

15. Birthplace Maryland

16 (a) Informant Russell L. Rice

(b) Address Balti. Ave. Cumberland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9, 1940 (month) (day) (year)

(c) Cemetery or crematory HillCrest Cem.

Location Cumberland

18 (a) Funeral director J. C. Wolford

(b) Address Cumberland, Md.

19 (a) June 8, 1940 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. Date of death June 7, 1940, at 4^05 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7/40 19__, to 6/7/40 19__, and that I last saw him alive on 6/7/40 19__.

Immediate cause of death Chronic Myocarditis

Due to Myocarial Failure

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Richard J. Williams, M.D. (M. D. or other)

Address 34 Va. Ave. Cumberland Md. Date signed 6/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

06161

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 528 North Mechanic St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 17 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 528 North Mechanic Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: -

**3. (a) FULL NAME:** Thomas E. Robertson

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife: -

6(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): September 28, 1891.

8. AGE: Years: 48 | Months: 8 | Days: 29 | If less than one day: hrs. min.

9. Birthplace: Swaconing, Allegany Co., Maryland (Town, county, and state)

10. Usual occupation: Driver (Retired)

11. Industry or business: Bakery

FATHER — 12. Name: William Robertson
13. Birthplace: Unknown

MOTHER — 14. Maiden name: Rachael McBride
15. Birthplace: New York, N. Y.

16. Informant: Mrs. Thomas Robertson
Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 30, 1940 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Swaconing, Md.

18. Funeral director: M. Eichhorn,
Address: Swaconing, Md.

19. June 27 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1940, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1940 to June 27 1940, and that I last saw him alive on June 27 1940.

| | DURATION |
|---|---|
| Immediate cause of death: Organic Heart disease, Endocarditis | |
| Due to: ulcer of stomach | 4 yrs |
| Due to: Chronic Nephritis | 1 yr |
| Other conditions: Hemorrhage of stomach | 1 wk |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

**22. VIOLENCE:** If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thos E. Robertson M. D. of other
Address: Cumberland Md Date signed:

RECEIVED
JUL 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

# CERTIFICATE OF DEATH

06162

Reg. Dist. No. 2

**1. PLACE OF DEATH:**

County Allegany

City or town Westernport

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Reeves Clinic

Stay in hospital or inst. (yrs., or mos., or days) 10 days

Stay in this community (yrs., or mos., or days) 33 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Mc Coole Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 425 Md. Ave

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Samantha Etta Robertson

**3. (b) Social Security Number** none

4. Sex: F

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Chas A. Robertson

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 15, 1873

8. AGE: Years 66 | Months 6 | Days 15 | If less than one day ____ hrs. ____ min.

9. Birthplace: Allegany Co., Md (Town, county, and state)

10. Usual occupation: Housekeeper & Home

11. Industry or business

FATHER 12. Name: Luther Ravenscroft

13. Birthplace: Md do not know

MOTHER 14. Maiden name: Mary Margaret Ravenscroft

15. Birthplace: Alle Co. Md.

18. Informant: A. A. Robertson

Address: Mc Coole, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 2/40 (month) (day) (year)

Cemetery or crematory: Dawson Cem

Location: Dawson, Md

18. Funeral director: J. H. Markwood Son

Address: Keyser, W. Va.

19. July 1 19 40 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1940, at 4:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1940, to June 30 1940, and that I last saw h[illegible] alive on June 30, 1940 19 ____.

| Immediate cause of death | DURATION |
|---|---|
| Diabetes Mellitus | 1 yr |
| Cerebral Thrombosis — Left hemiplegia | 4 wks |
| Due to Arteriosclerosis | |
| Due to | |
| Other conditions Pneumonia (terminal) | 2 days |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE J. Norman Reeves M D (M. D. or other)

Address Westernport, Md. Date signed 6-30-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 5 1940
BUREAU V. S.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

06163

**1. PLACE OF DEATH**

County Allegany — Registration Dist. No. 6

Village or City Westernport — No. Reeves Clinic St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. 8 ds. How long in U. S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

**2. FULL NAME** Jacob Henry Rotruck — If U. S. Veteran, specify WAR ___

(a) Residence: No. McCoole, Maryland St., Ward. (Usual place of abode) — If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| male | White | Married |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Matilda Rotruck

6. DATE OF BIRTH (month, dey, and year): September 1856

| 7. AGE Years | Months | Deys | If LESS than 1 day, ___ hrs. or ___ min. |
|---|---|---|---|
| 83 | 9 | | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Retired

10. Date deceased last worked at this occupation (month and year) ___ — 11. Total time (years) spent in this occupation ___

12. BIRTHPLACE (city or town) (State or country): Grant Co. W. Va.

FATHER

13. NAME: John Rotruck

14. BIRTHPLACE (city or town) (State or country): Grant Co. W. Va.

MOTHER

15. MAIDEN NAME: (unknown) Liller

16. BIRTHPLACE (city or town) (State or country): ~~unknown~~, Ridgeville Mineral Co. West Va.

17. INFORMANT (Address): Alva F. Rotruck, 594 S. Main Keyser, W. Va.

18. BURIAL, CREMATION, OR REMOVAL — Place: Knobley Cem. antioch, W. Va — Date: 6-17, 1940

19. UNDERTAKER (Address): N. H. Rogers, Keyser, W. Va.

20. FILED June 17, 1940 — A. J. Fazenbaker M.D. Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** June (Month) 15 (Day) 1940 (Year)

22. I HEREBY CERTIFY That I attended deceased from June 9, 1940, to June 15, 1940. I last saw him alive on June 15, 1940; death is said to have occurred on the date stated above, at 8 A. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

| | Date of onset |
|---|---|
| La Grippe | 6-9-40 |
| Pneumonia (terminal) | 6-13-40 |

Other Contributory Causes of importance: Arterio-Sclerosis, Senility

Name of operation ___ Date of ___

What test confirmed diagnosis? ___ Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of Injury ___, 19___

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury ___

Nature of Injury ___

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ___

(Signed) Norman Reeves M. D.

(Address) Westernport, Md.

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

RECEIVED JUL 5 1940 BUREAU V S

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (84-C)

06164

# CERTIFICATE OF DEATH

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

**1. PLACE OF DEATH:**

County: Alleganey

City or town: Barton, Md. rural near.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 26yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Alleganey

City or town: Barton, Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Margaret Ann Koontz Schaerrer

**3. (b) Social Security Number:** 216-09-7673

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Vernon V. Shaeffer

7. Birth date of deceased (mo., day, yr.): April 20, 1882 (If alive, [illegible] years)

8. AGE: Years: 58 Months: 2 Days: 8 If less than one day: hrs. min.

9. Birthplace: Wheelersville Pa. (Town, county, and state)

10. Usual occupation: Paper mill worker

11. Industry or business: Plup and paper mill

FATHER 12. Name: Steven Koontz

13. Birthplace: Lonaconing, Md

MOTHER 14. Maiden name: Rachael Durst

15. Birthplace: New Germany, Md

16. Informant: Kenneth Schaeffer

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 1, 1940 (month) (day) (year)

Cemetery or crematory: Philos

Location: Westernport, Md.

18. Funeral director: D.S.Boal.

Address: Westernport, Md.

19. July 1st 1940 (Date received by registrar) S. A. Boucher Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28 19 40, at 10.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1940, to June 28 1940, and that I last saw h[illegible] alive on June 28 1940

| | DURATION |
|---|---|
| Immediate cause of death: Starvation | 3 wks |
| Due to: Manic - Depressive Psychosis | 6 months |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: P E Berry M. D. or other

Address: Piedmont W Va Date signed 7/1/40

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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (139-6)

# CERTIFICATE OF DEATH

Dr Diehl

061659

Reg. Dist. No. 9

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 117 Mt Pleasant (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Wallace Seifert

**3. (b) Social Security Number:** None

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ernest Seifert

6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Sept 6 — 1885

**8. AGE:** Years: 55 Months: 9 Days: 13 If less than one day: hrs. min.

9. Birthplace: Huffman - alleg - md. (Town county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Thomas Close
13. Birthplace: Eckhart, md

MOTHER
14. Maiden name: Lucretia Bolie
15. Birthplace: Richmond, Va

16. Informant: Ernest Seifert

Address: Frostburg, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 22-1940 (month) (day) (year)

Cemetery or crematory: St. Michaels

Location: Frostburg, md.

18. Funeral director: J. J. Durst

Address: Frostburg

19. 6-21 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1940, at 9:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1940, to June 19 1940; and that I last saw her alive on June 19 1940.

Immediate cause of death: Pulmonary embolus

Due to: following operation as below.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Uterine suspension Perineoraphy

Of autopsy:

DURATION: 6-19-40

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other

Address: Frostburg, Md. Date signed: 6/21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

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WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06166

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County: Allegany County
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 10 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: W. VA. County: Hampshire
City or town: Springfield
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** JERRY C. SHANNON

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: May Taylor
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 6, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| ~~1~~ 63 | 8 | 7 | hrs. min. |

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business

FATHER
12. Name: Jerry C. Shannon
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Florence Bryan
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 16, 1940 (month) (day) (year)
Cemetery or crematory: Springfield Cem.
Location: Springfield, W. Va.

18. Funeral director: W. B. Guthrie
Address: Springfield W. Va.

19. June 13 1940 (Date rec'd by registrar) J. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13th, 1940 at 8:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15, 1940 to 6-18-1940 and that I last saw h... alive on 6-13-40 1940

Immediate cause of death: Acut Myocarditis — DURATION: 6-12-40
Due to: 2
Due to:
Other conditions: Pulmonary edema
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. C. Zimmerman M. D. or other
Address: Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. ZIMMERMAN

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JUL 8 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1 (55-8)

## CERTIFICATE OF DEATH

06167

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
County: Alleganey
City or town: Luke
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Cromwell
Stay in hospital or inst. (yrs., or mos., or days): 4 months
Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: W.Va. County: Tucker
City or town: Davis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Thomas Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ------

**3. (a) FULL NAME:** David Patrick Shoemaker

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife: Fanny Dennison
6(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1860

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 9 | 2 | ---- hrs. ---- min. |

9. Birthplace: Purgittsville, Hampshire, W.Va.
(Town, county, and state)

10. Usual occupation: Machinist.

11. Industry or business: Paper Mill

FATHER
12. Name: William Shoemaker
13. Birthplace: Purgittsville, W.Va.

MOTHER
14. Maiden name: Sally Kelly
15. Birthplace: Purgittsville, W.Va.

16. Informant: Mrs. James Jack.
Address: Luke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 9, 1940 (month) (day) (year)

Cemetery or crematory: Philos
Location: Westernport, Md.

18. Funeral director: D.S. Boal
Address: Westernport, Md.

19. June 8 19 40 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7, 1940, at 12:01 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1940, to June 7 1940, and that I last saw him alive on June 7 1940.

Immediate cause of death: Sarcoma large face with general Metastasis — DURATION: 6 Months

Due to: ----

Due to: ----

Other conditions: ----

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Sarcoma
Of autopsy: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: ---- Date of: ----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: ---- Injured at work?: ----

23. SIGNATURE: Paul R. Wilson M.D.
M. D. or other

Address: Piedmont, W.Va. Date signed: 6-8-40

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BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

06168

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH**

County: Allegany

City or town: Cumberland.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 103 Knox St.

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 58 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 103 Knox St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

**3. (a) FULL NAME:** John William Stark

**3. (b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | White | Married |

6 (b) Name of husband or wife: Helen Cook

6(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): May 11 1882

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | — | 26 | ____ hrs. ____ min. |

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: none.

11. Industry or business:

FATHER

12. Name: George Stark

13. Birthplace: Germany.

MOTHER

14. Maiden name: Elizabeth Froehlich

15. Birthplace: Germany.

16. Informant: Mrs Helen Stark

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8 40 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. June 8, 19 40 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7 1940, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1938, to June 7 1940, and that I last saw him alive on June 6 1940.

| | DURATION |
|---|---|
| Immediate cause of death: Myocarditis Chr. | 2 yrs. |
| Due to: | |
| Due to: | |
| Other conditions: Taken Dorsales | 15 yrs. |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of Injury: Injured at work?

23. SIGNATURE: Walter R. Straub M. D. or other

Address: Cumberland Md Date signed: 6/9/40

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JUL 8 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06169

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Miners Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Eckhart Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Nath. Highway
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Minnie Stewart

**3. (b) Social Security Number:** None

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Ray Stewart
6(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): May 4 - 1887
8. AGE: Years: 53 Months: 1 Days: 17 If less than one day: hrs. min.
9. Birthplace: Eckhart - Allegy - Md.
(Town, county, and state)
10. Usual occupation: home wife
11. Industry or business:
FATHER 12. Name: John Dudley
13. Birthplace: Scotland
MOTHER 14. Maiden name: Elizabeth Hamilton
15. Birthplace: U.S.A.
16. Informant: Ray Stewart
Address: Eckhart, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24-1940 (month) (day) (year)
Cemetery or crematory: Eckhart
Location: Eckhart, Md.
18. Funeral director: J. E. Dunn
Address: Frostburg, Md.
19. 6-21 1940 (Date rec'd by registrar) mrs. a. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1940, at 11:50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1940, to June 21 1940, and that I last saw her alive on June 21 1940.

| | DURATION |
|---|---|
| Immediate cause of death: Vaso-motor Collapse following thyroidectomy; | 6-19-40. |
| Due to: Primary Cause Toxic goiter. | |
| Due to: thyrotoxicosis cause | |
| Other conditions: | |

(Include pregnancy within 3 months of death)
Major findings:
Of operations: Thyroidectomy 6/19/40
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D.
M. D. or other
Address: Frostburg, Md Date signed: 6/21/40

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JUL 3 1940
BUREAU

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (S)

# CERTIFICATE OF DEATH

C6170

Reg. Dist. No. 4

(M) (S)

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Ridgeley Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R. F. D.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: no

**3. (a) FULL NAME:** Stillborn Stinebaugh

**3. (b) Social Security Number:** no

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ✓

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 19, 1940

8. AGE: Years: Still Months: born Days: If less than one day ____ hrs. ____ min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Champ Henry Stinebaugh
13. Birthplace: Great Capton Wa

MOTHER
14. Maiden name: Hattie McCarthy
15. Birthplace: Cumberland Md

16. Informant: Champ H. Stinebaugh
Address: Ridgeley R. F. D. Wa

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof: June 20, 1940 (month) (day) (year)

Cemetery or crematory: abc Cem

Location: Mineral Co. W. Va.

18. Funeral director: Louis Stein Inc.
Address: Cumberland Md.

19. June 20 1940 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1940, at 7:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1940, to June 19 1940, and that I last saw h____ alive on ____ 19____

Immediate cause of death: Stillborn

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature]
M. D. or other

Address: 33 Va Ave Date signed: 6/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 8 1940
MINERALS Y. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

## CERTIFICATE OF DEATH

06171

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
913 Frederick Street

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 913 Frederick St.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** James Martin Swick

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife Mary Magdalene Swick

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) August 10th. 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 8 | 10 | ..... hrs. ..... min. |

9. Birthplace Petersburg, W. Va.
(Town, county, and state)

10. Usual occupation Carman, retired

11. Industry or business Balt. and Ohio RR

FATHER 12. Name John Swick

13. Birthplace Virginia

MOTHER 14. Maiden name Jane Lewis

15. Birthplace unknown

16. Informant Mrs. Rosa Haines

Address 64 Vernon St. Keyser, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22 -40 (month) (day) (year)

Cemetery or crematory Philos

Location Westernport, Md

18. Funeral director N.L. Rogers Funeral Directors

Address Keyser, W. Va.

19. June 21, 1940 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 21st., 1940 about 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bruce H. Lorson, M.D.
M. D. or other

Address Cumberland, Maryland. Date signed 6/22/40

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (148)

C13

06172

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 3½ hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State WEST VIRGINIA County HAMPSHIRE
City or town SPRINGFIELD
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** MRS. MABEL WAGONER

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | MARRIED |

6.(b) Name of husband or wife ELMER WAGONER
6.(c) If alive, give age 30 years
7. Birth date of deceased (mo., day, yr.) APRIL 9, 1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | 1 | 23 | hrs. min. |

9. Birthplace WEST VIRGINIA (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name FRANK BEAN, MR.
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name JULIA ANN MALONE
15. Birthplace WEST VIRGINIA

16. Informant Memorial Hosp.
Address Cumberland Md
17. Burial, cremation, or removal. Which? Springfield Date thereof June 4, 1940 (month) (day) (year)
Cemetery or crematory
Location Springfield W. Va.
18. Funeral director Garland T. Griffith
Address Springfield W. Va.
19. June 4 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION** P.M

20. DATE OF DEATH JUNE 2 1940 3:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1940, to June 2 1940 and that I last saw h[illegible] alive on June 2/40 1940

| Immediate cause of death | DURATION |
|---|---|
| Pregnancy at term. | |
| Eclampsia. | |
| Due to | |
| | |
| Due to | |
| Other conditions | |

(include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dwight Reynolds M.D. M. D. or other
Address Cumberland Md. Date signed June 2/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

06173

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: D.C. Cyland County: ~~Allegany~~

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Receiving Station Navy Yard

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** Mr. Richard Wilcox

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife: ——

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 6 1916

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | 0 | 25 | ..... hrs. ..... min. |

9. Birthplace: W.Va. (Town, county, and state)

10. Usual occupation:

11. Industry or business: Navy Yard, Washington D.C.

FATHER

12. Name: Byron Wilcox

13. Birthplace: West Virginia

MOTHER

14. Maiden name: Ethel Nutter

15. Birthplace: West Virginia

16. Informant: Mrs Ethel Wilcox

Address: Clarksburg West Va

17. Removal (Burial, cremation, or removal. Which?) Date thereof: June 4 1940 (month) (day) (year)

Cemetery or crematory:

Location: Clarksburg West Va

18. Funeral director: Jane's Stein Inc

Address: Cumberland Md

19. June 1, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr Grove

### MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1 1940 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1940, to June 1, 1940 and that I last saw him alive on May 31, 1940

| Immediate cause of death | DURATION |
|---|---|
| Fractured spine | 1 day |
| Compound fracture right leg | " |
| Due to Lacerated urethra | " |
| Probable injured kidney | " |
| Due to | |

Other conditions: Contusions & lacerations of body

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 5/30/40

Where did injury occur? Hampshire, W. Va. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) public pl. (road)

Means of injury: Automobile accident Injured at work?

23. SIGNATURE: D. C. Grove, M.D. M. D. or other

Address: Medical Bldg Date signed 6/1/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (8) Reg. Dist. No. 9 — 06174

## CERTIFICATE OF DEATH

**1. PLACE OF DEATH:**
(a) County Allegany
(b) City or town Frostburg
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Miners Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in this community (yrs., mos., or days)

**2. HOME (USUAL RESIDENCE) OF DECEASED:**
(a) State MD. (b) County Allegany
(c) City or town Mt. Savage
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME (FETUS) WINEBRENNER

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/27/40

8. AGE: Years | Months | Days | If less than one day: hr. min.
FETUS - 3 MONTHS

9. Birthplace Frostburg Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name RAYMOND WINEBRENNER
13. Birthplace MT. SAVAGE, MD

MOTHER
14. Maiden Name EVELYN L. CASSIDY
15. Birthplace WHEELING, W. VA

16 (a) Informant RAYMOND WINEBRENNER
(b) Address MT. SAVAGE, MD.

17 (a) DISPOSAL (Burial, cremation, or removal) (b) Date thereof 6/27/40 (month) (day) (year)
(c) Cemetery or crematory Hospital
Location Frostburg Md.

18 (a) Funeral director None
(b) Address

19 (a) 6-27-40 (Date rec'd by registrar) (b) mo. A. R. Tucker Registrar

**MEDICAL CERTIFICATION**

20. Date of death 6/27/40 19___, at 4 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/27/40 19___, to 6/27/40 19___, and that I last saw him alive on # 19___.

| Immediate cause of death | Duration |
|---|---|
| PREMATURITY | |
| Due to STILL BORN | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Kilday M.D.
M. D. or other
Address Frostburg, Md. Date signed 6/28/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 3 1940
BUREAU

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-D)

## CERTIFICATE OF DEATH

06175

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 415

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 20n Baltimore Ave.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 29 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 20n Baltimore Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

**3. (a) FULL NAME:** Walter E Wise

**3. (b) Social Security Number:** 705-12-4291

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married, |

6 (b) Name of husband or wife: Gertrude E. Wise
6(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Feb 21, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 3 | 16 | hrs. min. |

9. Birthplace: Brookfield, Pa
(Town, county, and state)

10. Usual occupation: Conductor

11. Industry or business: Railroad

FATHER
12. Name: John H. Wise
13. Birthplace: ~~Unknown~~ W. Va.

MOTHER
14. Maiden name: Carrie Barr
15. Birthplace: Unknown

16. Informant: Gertrude E. Wise
Address: 20n Baltimore ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 10, 1940 (month) (day) (year)
Cemetery or crematory: Hyndman Cemetary
Location: Hyndman, ~~Penna~~ Pa.

18. Funeral director: Jacob Hoffer
Address: 230 Baltimore Ave.

19. June 9, 1940 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

Fred Williams

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-7-1940, 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-5-1939, to 6-7-1940 and that I last saw h~~im~~ alive on 6-7-1940

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of Lung. | 1 yr. |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operation: Bronchoscopy + biopsy confirmed dx
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Fred X. Williams M. D. or other
Address: Cumberland Date signed: 6-8-40

RECEIVED
JUN 13 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

# CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS

M Lane

061769

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 day

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 144 Green St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** James Allard Yates

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 5, 1927

8. AGE: Years 12 | Months 9 | Days 26 | If less than one day: hrs. min.

9. Birthplace: Frostburg Maryland (Town, county, land state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Isaac Yates

13. Birthplace: Frostburg Md.

MOTHER — 14. Maiden name: Mary Rankin

15. Birthplace: Frostburg, Md.

16. Informant: Mrs. Isaac J. Yates

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4-1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md

18. Funeral director: J. J. Hurst,

Address: Frostburg, Md.

19. 6-4 1940 (Date rec'd by registrar) Mrs. C. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1 1940, at 8:39 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21 1940, to June 1 1940, and that I last saw him alive on June 1 1940.

| | DURATION |
|---|---|
| Immediate cause of death: General Peritonitis, | 1 day |
| Due to: Ruptured Appendix | 12 day |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Gen. Peritonitis appendicial abscess

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John C. Lane Jr. M.D. M. D. or other

Address: Frostburg Md Date signed: June 3 1940

RECEIVED
JUL 3 1940
BUREAU V. S.